

IHCP Provider Enrollment Type and Specialty Matrix

All provider types and specialties listed in this document as eligible to enroll in the Indiana Health Coverage Programs (IHCP) can apply online through the [Provider Healthcare Portal](#). Providers who choose to enroll by mail can go to the [Complete an IHCP Provider Enrollment Application](#) web page, select the applicable provider type, and download the appropriate enrollment packet. For more information about enrolling as an Indiana Medicaid provider, see the [Provider Enrollment](#) IHCP provider reference module.

All links above are accessible from the IHCP provider website at in.gov/medicaid/providers.

Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
01 – Hospital	010 – Acute Care	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) certification Medicare number required for each service location Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state Medicare number required for each service location Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹
01 – Hospital	011 – Psychiatric Facility (Freestanding or with independent organizational structure; includes institutions for mental disease [IMDs])	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet (or online application), which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form <i>IHCP Psychiatric Hospital Bed Addendum</i> (for facilities with 16 beds or less), if applicable Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Division of Mental Health and Addiction (DMHA) Private Mental Health Facility license or Indiana State Department of Health (ISDH) certification Medicare number required for each service location Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form <i>IHCP Psychiatric Hospital Bed Addendum</i> (for facilities with 16 beds or less), if applicable Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of appropriate license from appropriate state Medicare number required for each service location Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](#) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](#) web page at in.gov/medicaid/providers.

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01 – Hospital	012 – Rehabilitation (Distinct part or unit)	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) certification Medicare number required for each service location Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state Medicare number required for each service location Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹
01 – Hospital	013 – Long Term Acute Care (LTAC)	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application (indicate update to a current provider number), which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) license complying with <i>IC 16-21</i> for LTAC Copy of Centers for Medicare & Medicaid Services (CMS) LTAC approval letter Medicare number required for each service location Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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02 – Ambulatory Surgical Center	020 – Ambulatory Surgical Center (ASC)	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) certification Medicare number, if enrolled in Medicare Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹
03 – Extended Care Facility	030 – Nursing Facility 031 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) 032 – Pediatric Nursing Facility 033 – Residential Care Facility	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) certification Medicare number, if enrolled in Medicare Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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03 – Extended Care Facility	034 – Psychiatric Residential Treatment Facility (PRTF)	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) certification Indiana Department of Child Services (DSC) residential child care license for a private, secure care facility Copy of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Council on Accreditation (COA) credentials Attestation letter for facility compliance Medicare number, if enrolled in Medicare Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
04 – Rehabilitation Facility	040 – Rehabilitation Facility	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) certification Medicare number, if enrolled in Medicare Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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04 – Rehabilitation Facility	041 – Comprehensive Outpatient Rehabilitation Facility (CORF)	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) certification Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group Medicare number required for each service location Application fee required ¹ <p><i>Note: Per CMS requirements – Facility must have on staff: physician and HSPP mental health provider and physical therapist</i></p>	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
05 – Home Health Agency	050 – Home Health Agency	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Indiana State Department of Health (ISDH) license Medicare number, if enrolled in Medicare Application fee required ¹ Fingerprinting and background check required ² 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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06 – Hospice	060 – Hospice	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of hospice license Medicare number required for each service location Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
08 – Clinic	080 – Federally Qualified Health Center (FQHC)	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of CMS approval letter verifying FQHC enrollment <i>for each location</i> Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group Medicare number, if enrolled in Medicare Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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08 – Clinic	081 – Rural Health Clinic (RHC)	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group Copy of CMS approval letter verifying RHC enrollment for each location, if applicable Medicare number, if enrolled in Medicare Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
08 – Clinic	082 – Medical Clinic	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state for rendering providers linked to the group Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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08 – Clinic	083 – Family Planning Clinic	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state for rendering providers linked to the group Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled
08 – Clinic	084 – Nurse Practitioner Clinic	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state for rendering providers linked to the group Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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08 – Clinic	086 – Dental Clinic	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable For a sole proprietorship, partnership, or professional services corporation, all entities with an ownership or control interest, as disclosed on the provider enrollment application, must have dental licenses Medicare number, if enrolled in Medicare <p><i>Note: A dental practice must be owned by a dentist.</i></p>	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable For a sole proprietorship, partnership, or professional services corporation, all entities with an ownership or control interest, as disclosed on the provider enrollment application, must have dental licenses Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled <p><i>Note: A dental practice must be owned by a dentist.</i></p>
08 – Clinic	087 – Therapy Clinic	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Medicare number, if enrolled in Medicare Application fee required ¹ <p><i>Note: Per CMS requirements – Clinic must have two enrolled physicians plus one or more therapists.</i></p>	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹ <p><i>Note: Per CMS requirements – Clinic must have two enrolled physicians plus one or more therapists.</i></p>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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08 – Clinic	088 – Birthing Center	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Medicare number, if enrolled in Medicare <p><i>Note: Per CMS requirements – Clinic must have a physician and/or midwife on staff.</i></p>	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled <p><i>Note: Per CMS requirements – Clinic must have a physician and/or midwife on staff.</i></p>
09 – Advanced Practice Registered Nurse	090 – Pediatric Nurse Practitioner 091 – Obstetric Nurse Practitioner 092 – Family Nurse Practitioner 093 – Nurse Practitioner (other, for example, clinical nurse specialist) 094 – Certified Registered Nurse Anesthetist (CRNA) 095 – Certified Nurse Midwife	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from Indiana Professional Licensing Agency (IPLA) Copy of Nurse Practitioner (NP) certification from accredited NP certifying organization Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the appropriate state If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification Copy of Nurse Practitioner (NP) certification from accredited NP certifying organization Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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10 – Physician Assistant	100 – Physician Assistant	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from Indiana Professional Licensing Agency (IPLA) Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the appropriate state If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled
11 – Mental Health Providers	110 – Outpatient Mental Health Clinic	<ul style="list-style-type: none"> HCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Outpatient Mental Health Addendum Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Medicare number, if enrolled in Medicare 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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11 – Mental Health Provider	111 – Community Mental Health Center (CMHC)	<ul style="list-style-type: none"> • HCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> ○ Provider Agreement ○ Federal W-9 form ○ Outpatient Mental Health Addendum • Copy of certification from FSSA Division of Mental Health and Addiction (DMHA) • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Medicare number, if enrolled in Medicare • Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
11 – Mental Health Provider	114 – Health Service Provider in Psychology (HSPP)	<ul style="list-style-type: none"> • IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> ○ Provider Agreement ○ Federal W-9 form • Copy of license from Indiana Professional Licensing Agency (IPLA) • Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> • IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> ○ Provider Agreement ○ Federal W-9 form • Copy of license from appropriate state • Medicare number, if enrolled in Medicare • Proof of participation in own state's Medicaid program, if enrolled
11 – Mental Health Provider	115 – Adult Mental Health and Habilitation (AMHH) Service Provider	<ul style="list-style-type: none"> • IHCP Group provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> ○ Provider Agreement ○ Federal W-9 form ○ Outpatient Mental Health Addendum • Copy of certification from FSSA Division of Mental Health and Addiction (DMHA) • Medicare number, if enrolled in Medicare • Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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11 – Mental Health Provider	611 – Children’s Mental Health Wraparound (CMHW)	<ul style="list-style-type: none"> IHCP Group provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Outpatient Mental Health Addendum Copy of certification from FSSA Division of Mental Health and Addiction (DMHA) Medicare number, if enrolled in Medicare Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
11 – Mental Health Provider	612 – Behavioral and Primary Healthcare Coordination (BPHC)	<p>Not a stand-alone specialty; specialty can only be added to an enrolled community mental health center (CMHC).</p> <ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification to update specialty Copy of certification from FSSA Division of Mental Health and Addiction (DMHA) 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
11 – Mental Health Provider	613 – MRO Clubhouse	<p>Not a stand-alone specialty; specialty can only be added as a rendering provider contracted with an IHCP-enrolled community mental health center (CMHC).</p> <ul style="list-style-type: none"> IHCP Rendering provider enrollment packet or online application – To enroll as a rendering provider of psychosocial rehabilitation services IHCP MRO Clubhouse Provider Enrollment Addendum Copy of certification from the FSSA Division of Mental Health and Addiction (DMHA) 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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11 – Mental Health	615 – Applied Behavior Analysis (ABA) Therapist	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Behavior Analyst Certification Board (BACB) certification as a Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst-Doctoral (BCBA-D), or professional license as Health Service Provider in Psychology (HSPP) Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the appropriate state agency Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled
12 – School Corporation	120 – School Corporation	<ul style="list-style-type: none"> IHCP School Corporation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Must be listed on the approved Indiana Department of Education's school corporation list and charter school list 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
13 – Public Health Agency	130 – County Health Department	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
14 – Podiatrist	140 – Podiatrist	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from Indiana Professional Licensing Agency (IPLA) Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled
15 – Chiropractor	150 – Chiropractor	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from Indiana Professional Licensing Agency (IPLA) Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from appropriate state Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
17 – Therapist	170 – Physical Therapist 171 – Occupational Therapist 173 – Speech/Hearing Therapist	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from Indiana Professional Licensing Agency (IPLA) Medicare number, if enrolled in Medicare Application fee required if enrolling as a group ¹ 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from appropriate state Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required if enrolling as a group ¹
18 – Optometrist	180 – Optometrist	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from Indiana Professional Licensing Agency (IPLA) Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from appropriate state If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled
19 – Optician	190 – Optician	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from appropriate state, if that state licenses opticians Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
20 – Audiologist	200 – Audiologist	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from Indiana Professional Licensing Agency (IPLA) Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license from appropriate state, if that state licenses audiologists Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled
22 – Hearing Aid Dealer	220 – Hearing Aid Dealer	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Indiana Hearing Aid Dealer's License Medicare number, if enrolled in Medicare Application fee required ¹ Fingerprint and background check required ² 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of appropriate state's Hearing Aid Dealer's License Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹ Fingerprint and background check required ²

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
24 – Pharmacy	240 – Pharmacy 250 – Durable Medical Equipment (DME)/Medical Supply Dealer 251 – Home Medical Equipment (HME)	<ul style="list-style-type: none"> IHCP Pharmacy provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Indiana Pharmacy License Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy, if applicable Medicare number, if enrolled in Medicare Application fee required ¹ If DME 250 – Fingerprint and background check required ² If HME 251 – Fingerprint and background check required ² 	<ul style="list-style-type: none"> IHCP Pharmacy provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license or permit from appropriate state If supplying to residents of Indiana via mail or other delivery services, you must have an Indiana nonresident pharmacy license Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy, if applicable Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹ If DME 250 – Fingerprint and background check required ² If HME 251 – Fingerprint and background check required ²
25 – DME/Medical Supply Dealer	250 – DME/Medical Supply Dealer	<ul style="list-style-type: none"> IHCP Durable Medical Equipment provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Medicare number, if enrolled in Medicare Application fee required ¹ Fingerprint and background check required ² 	<ul style="list-style-type: none"> IHCP Durable Medical Equipment provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of license if state licenses DME providers Medicare number, if enrolled in Medicare If not Medicare enrolled, proof of participation in own state's Medicaid program required Application fee required ¹ Fingerprint and background check required ² <p><i>Note: Prior Authorization (PA) for services required.</i></p>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
25 – DME/Medical Supply Dealer	251 – HME/Home Medical Equipment	<ul style="list-style-type: none"> IHCP Durable Medical Equipment provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy Medicare number, if enrolled in Medicare Application fee required ¹ Fingerprint and background check required ² 	<ul style="list-style-type: none"> IHCP Durable Medical Equipment provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy (physical service location does not have to be in the state of Indiana, but you must obtain an Indiana HME license to provide services to Indiana residents) Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹ Fingerprint and background check required ² <p><i>Note: Prior Authorization (PA) for services required.</i></p>
26 – Transportation	260 – Ambulance	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Indiana Emergency Medical Services (EMS) Commission certification Medicare number, if enrolled in Medicare Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of appropriate state's emergency medical services (EMS) commission certification Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
26 – Transportation	261 – Air Ambulance	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Indiana Emergency Medical Services (EMS) Commission Air Ambulance certification Medicare number, if enrolled in Medicare Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of appropriate state's emergency medical services (EMS) commission certification Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹
26 – Transportation	262 – Bus	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Motor Carrier Services (MCS) certificate from the Indiana Department of Revenue Proof of insurance coverage as required by the Indiana motor carrier authority Copy of driver's license for all drivers Application fee required ¹ Fingerprint and background check required ² 	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of appropriate state's certification for buses Copy of Motor Carrier Service (MCS) certificate showing interstate authority, if the provider crosses state lines Proof of insurance, as indicated by local ordinances Copy of driver's license for all drivers Application fee required ¹ Fingerprint and background check required ²

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
26 – Transportation	263 – Taxi	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Document showing operating authority from the local governing body (city taxi or livery license) Copy of retail merchant's certificate (providers that have nonprofit status are exempt from this requirement) Proof of nonprofit status from the Internal Revenue Service (IRS), if applicable Proof of insurance, as indicated by local ordinances (if unspecified by local ordinance, a minimum of \$25,000/\$50,000 public livery insurance covering all vehicles used in the business) Copy of driver's license for all drivers Proof of Indiana surety bond of at least \$50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations or other exempted providers per <i>IC 12-15-11-2.5(b)</i>) Application fee required ¹ Fingerprint and background check required ² 	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Document showing taxi operating authority from the local governing body as a common carrier Copy of retail merchant's certificate (providers that have nonprofit status are exempt from this requirement) Proof of nonprofit status from the IRS, if applicable Proof of insurance as indicated by local ordinances (if unspecified by local ordinance, a minimum of \$25,000/\$50,000 public livery insurance covering all vehicles used in the business) Copy of driver's license for all drivers Proof of Indiana surety bond of at least \$50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations or other exempted providers per <i>IC 12-15-11-2.5(b)</i>) Application fee required ¹ Fingerprint and background check required ²

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
26 – Transportation	<p>264 – Common Carrier (Ambulatory)</p> <p>265 – Common Carrier (Non-Ambulatory)</p> <p><i>Ambulatory</i> means the clients are able to walk to and from or transfer into or out of the transporting vehicle.</p> <p><i>Non-ambulatory</i> means the clients need to remain in a wheelchair while being transported.</p>	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Motor Carrier Services (MCS) certificate from the Indiana Department of Revenue (for-profit providers only) Proof of nonprofit status from the Internal Revenue Service (IRS), if applicable Interstate carriers must submit their U.S. Department of Transportation (USDOT) number for verification Proof of insurance (providers with nonprofit status must have a minimum of \$500,000 of combined single-limit commercial automobile liability) Copy of driver's license for all drivers Proof of Indiana surety bond of at least \$50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations, providers owned or controlled by a hospital or pharmacy licensed in Indiana, or other exempted providers per <i>IC 12-15-11-2.5(b)</i>) Application fee required ¹ Fingerprint and background check required ² 	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form For interstate carriers, submission of the USDOT number for verification Copy of appropriate state's certification for common carriers Copy of Motor Carrier Service (MCS) certificate showing interstate authority, if the provider crosses state lines (for-profit providers only) Proof of nonprofit status from the IRS, if applicable Proof of insurance (providers with nonprofit status must have a minimum of \$500,000 of combined single-limit commercial automobile liability) Copy of driver's license for all drivers Proof of Indiana surety bond of at least \$50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations or other exempted providers per <i>IC 12-15-11-2.5(b)</i>) Application fee required ¹ Fingerprint and background check required ²

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

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Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
26 – Transportation	266 – Family Member	<ul style="list-style-type: none"> IHCP Family Member/Associate Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> IHCP Family Member/Associate Transportation Provider Agreement Federal W-9 form Medicaid Family Member or Associate Transportation Services Form, completed and signed by the member being transported Copy of current driver's license Copy of current auto insurance for the vehicle being used Copy of current auto registration for the vehicle being used 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
26 – Transportation	267 – Transportation Network Company (TNC)	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of TNC permit from the Indiana Department of Revenue Proof of insurance Proof of Indiana surety bond of at least \$50,000 for a minimum duration of 3 years (not required for providers owned or controlled by a hospital or pharmacy licensed in Indiana or for other exempted providers per <i>IC 12-15-11-2.5(b)</i>) Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
26 – Transportation	268 – Nursing Home Transportation	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Proof of nonprofit status from the Internal Revenue Service (IRS), if applicable Proof of insurance Copy of driver's license for all drivers Proof of Indiana surety bond of at least \$50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations, providers owned or controlled by a hospital or pharmacy licensed in Indiana, or other exempted providers per IC 12-15-11-2.5(b)) 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
26 – Transportation	269 – Broker Fleet	<ul style="list-style-type: none"> IHCP Transportation provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Motor Carrier Services (MCS) certificate from the Indiana Department of Revenue Proof of insurance Copy of driver's license for all drivers Proof of Indiana surety bond of at least \$50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations, providers owned or controlled by a hospital or pharmacy licensed in Indiana, or other exempted providers per IC 12-15-11-2.5(b)) 	<ul style="list-style-type: none"> Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
27 – Dentist	270 – Endodontist 271 – General Dentistry Practitioner 272 – Oral Surgeon 273 – Orthodontist 274 – Pediatric Dentist 275 – Periodontist 277 – Prosthesis	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from Indiana Professional Licensing Agency (IPLA) For a sole proprietorship, partnership, or professional services corporation (PSC), the owners listed as disclosed entities on the provider enrollment application must have dental licenses Medicare number, if enrolled in Medicare <p><i>Note: A dental practice must be owned by a dentist.</i></p>	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from state where services are performed For a sole proprietorship, a partnership, or professional services corporation, the owners listed as disclosed entities on the provider enrollment application must have dental licenses Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled <p><i>Note: A dental practice must be owned by a dentist.</i></p>
27 – Dentist	276 – Mobile Dental Van	<ul style="list-style-type: none"> IHCP Group and Clinic provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of registration from Indiana Professional Licensing Agency (IPLA) Copy of license from IPLA for rendering providers Copy of valid Indiana driver's license for all drivers Medicare number, if enrolled in Medicare 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
28 – Laboratory	280 – Independent Lab	<ul style="list-style-type: none"> IHCP Billing provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required Medicare number, if enrolled in Medicare Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Billing provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹
28 – Laboratory	281 – Mobile Lab	<ul style="list-style-type: none"> IHCP Billing provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required Copy of valid driver's license for all drivers Medicare number, if enrolled in Medicare Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Billing provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required Copy of valid driver's license for all drivers Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
28 – Laboratory	282 – Independent Diagnostic Testing Facility (IDTF)	<ul style="list-style-type: none"> IHCP Group provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Medicare number, if enrolled in Medicare Application fee required ¹ <p><i>Note: Per CMS requirements – Must have a physician on staff</i></p>	<ul style="list-style-type: none"> IHCP Group provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹ <p><i>Note: Per CMS requirements – Must have a physician on staff</i></p>
28 – Laboratory	283 – Mobile Independent Diagnostic Testing Facility (IDTF)	<ul style="list-style-type: none"> IHCP Billing or Group provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of valid driver's license for all drivers Medicare number, if enrolled in Medicare Application fee required ¹ <p><i>Note: Per CMS requirements – Must have a physician on staff</i></p>	<ul style="list-style-type: none"> IHCP Billing or Group provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of appropriate state's valid driver's license for all drivers Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹ <p><i>Note: Per CMS requirements – Must have a physician on staff</i></p>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://www.in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
29 – Radiology	290 – Freestanding X-Ray Clinic 291 – Mobile X-Ray Clinic	<ul style="list-style-type: none"> IHCP Radiology provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of registration certificate Notice of Indiana State Department of Health (ISDH) compliance Copy of operator certificates for all employee operators, except positron emission tomography – computed tomography (PET CT) scanner operators <ul style="list-style-type: none"> PET and magnetic resonance imaging (MRI) services do not require certification or notice of compliance Copy of valid driver's license for all drivers, if applicable Medicare number, if enrolled in Medicare Application fee required ¹ 	<ul style="list-style-type: none"> IHCP Radiology provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of registration certificate Out-of-state mobile radiology providers (specialty 291) performing services in Indiana must be certified in Indiana and possess a Notice of Compliance in Indiana. Copy of operator certificates for all employee operators, except positron emission tomography – computed tomography (PET CT) scanner operators <ul style="list-style-type: none"> PET and magnetic resonance imaging (MRI) services do not require certification or notice of compliance For out-of-state mobile radiology providers (specialty 291), all operators (except PET CT scanner operators) must be certified in the state of Indiana Copy of license from appropriate state Copy of valid driver's license for all drivers, if applicable Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
30 – End-Stage Renal Disease (ESRD) Clinic	300 – Freestanding Renal Dialysis Clinic	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required Copy of Indiana State Department of Health (ISDH) certification Medicare number, if enrolled in Medicare Application fee required ¹ 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.
31 – Physician	310 – Allergist 311 – Anesthesiologist 312 – Cardiologist 313 – Cardiovascular Surgeon 314 – Dermatologist 315 – Emergency Medicine Practitioner 316 – Family Practitioner 317 – Gastroenterologist 318 – General Practitioner 319 – General Surgeon 320 – Geriatric Practitioner 321 – Hand Surgeon 323 – Neonatologist 324 – Nephrologist 325 – Neurological Surgeon 326 – Neurologist 327 – Nuclear Medicine Practitioner	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the Indiana Professional Licensing Agency (IPLA) Copy of board certification for specialty requested, if applicable Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from appropriate state If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification Copy of board certification for specialty requested, if applicable Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
	328 – Obstetrician/Gynecologist 329 – Oncologist 330 – Ophthalmologist 331 – Orthopedic Surgeon 332 – Otologist, Laryngologist, Rhinologist 333 – Pathologist 334 – Pediatric Surgeon 336 – Physical Medicine and Rehabilitation Practitioner 337 – Plastic Surgeon 338 – Proctologist 339 – Psychiatrist 340 – Pulmonary Disease Specialist 341 – Radiologist 342 – Thoracic Surgeon 343 – Urologist 344 – General Internist 345 – General Pediatrician 346 – Dispensing Physician		
32 – Waiver Provider	<i>See pages 34–38.</i>		

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
34 – MRT Copy Center	366 – MRT Copy Center	<ul style="list-style-type: none"> IHCP Billing provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form 	<ul style="list-style-type: none"> IHCP Billing provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Proof of participation in own state's Medicaid program, if enrolled
35 – Addiction Services	835 – Opioid Treatment Program	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of Drug Enforcement Agency (DEA) registration certificate Copy of Division of Mental Health and Addiction (DMHA) Opioid Treatment Program certification Medicare number, if enrolled in Medicare 	Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
35 – Addiction Services	836 – Substance Use Disorder (SUD) Residential Addiction Treatment Facility	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Provider must provide one of the following: <ul style="list-style-type: none"> Copy of a Division of Mental Health and Addiction (DMHA) certification as a Sub-Acute Facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services Proof of Department of Child Services (DCS) licensing as a child care institution or private secure-care institution with a DMHA Addiction Services Provider Regular Certification that includes an ASAM designation of offering either Level 3.1 or Level 3.5 residential services Facilities that have designations to offer both ASAM Level 3.1 and Level 3.5 services within the facility must include proof of both designations with their enrollment application. Copy of Drug Enforcement Agency (DEA) registration certificate (optional) Medicare number, if enrolled in Medicare Application fee required¹ 	<ul style="list-style-type: none"> IHCP Hospital and Facility provider enrollment packet or online application, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Provider must provide one of the following: <ul style="list-style-type: none"> Copy of a Division of Mental Health and Addiction (DMHA) certification as a Sub-Acute Facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services Proof of Department of Child Services (DCS) licensing as a child care institution or private secure-care institution with a DMHA Addiction Services Provider Regular Certification that includes an ASAM designation of offering either Level 3.1 or Level 3.5 residential services. Facilities that have designations to offer both ASAM Level 3.1 and Level 3.5 services within the facility must include proof of both designations with their enrollment application. Copy of Drug Enforcement Agency (DEA) registration certificate (optional) Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled Application fee required¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code & Description	Provider Specialty Code & Description	In-State Provider Document Requirements	Out-of-State Provider Document Requirements
36 – Genetic Counselor	800 – Genetic Counselor	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from Indiana Professional Licensing Agency (IPLA) Medicare number, if enrolled in Medicare 	<ul style="list-style-type: none"> IHCP provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable Copy of license from the appropriate state Medicare number, if enrolled in Medicare Proof of participation in own state's Medicaid program, if enrolled

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

IHCP Provider Enrollment Type and Specialty Matrix



Home and Community-Based Services (HCBS) Waiver Providers

Provider Type Code	Provider Specialty Codes	Provider Secondary Specialty Codes	In-State Provider Document Requirements ³
32 – Waiver	350 – Aged and Disabled (AD) Waiver	A00 – Adult Day Services (Level 1) A01 – Adult Day Services (Level 2) A02 – Adult Day Services (Level 3) A03 – Adult Foster Care ¹ A04 – Assisted Living A05 – Attendant Care ² A06 – Case Management A07 – Community Transition Services A08 – Environmental Modifications A09 – Healthcare Coordination A10 – Home-Delivered Meals A11 – Homemaker A12 – Nutritional Supplements A13 – Pest Control A14 – Respite A15 – Self-Directed Attendant Care A16 – Specialized Medical Equipment Supplies ^{1, 2} A17 – Transportation ¹ A18 – Vehicle Modifications A19 – Personal Emergency Response Systems A20 – Environmental Modifications Assessment A21 – Structured Family Caregiving	<ul style="list-style-type: none"> IHCP Waiver provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Certification letter from the appropriate waiver administering division A03 – Application fee required ¹ A05 – Fingerprint and background check required ² A16 – Application fee, fingerprint, and background check required ^{1, 2} A17 – Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](#) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](#) web page at in.gov/medicaid/providers.

³ Out-of-state providers must contact the appropriate waiver division for requirements.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code	Provider Specialty Codes	Provider Secondary Specialty Codes	In-State Provider Document Requirements ³
32 – Waiver	356 – Traumatic Brain Injury (TBI) Waiver	B00 – Adult Day Services (Level 1) B01 – Adult Day Services (Level 2) B02 – Adult Day Services (Level 3) B03 – Adult Foster Care ¹ B04 – Attendant Care ² B05 – Behavior Management/Behavior Program & Counseling B06 – Case Management B07 – Community Transition Services B08 – Environmental Modifications B09 – Healthcare Coordination B10 – Home-Delivered Meals B11 – Homemaker B12 – Nutritional Supplements B14 – Personal Emergency Response Systems B15 – Pest Control B17 – Residential Habilitation and Support B18 – Respite B19 – Specialized Medical Equipment & Supplies B21 – Structured Day Program B22 – Supported Employment Follow Along B23 – Transportation ¹ B24 – Vehicle Modifications B25 – TBI Assisted Living	<ul style="list-style-type: none"> IHCP Waiver provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Certification letter from the appropriate waiver administering division B03 – Application fee required ¹ B04 – Fingerprint and background check required ² B19 – Application fee, fingerprint, and background check required ^{1, 2} B23 – Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](http://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](http://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

³ Out-of-state providers must contact the appropriate waiver division for requirements.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code	Provider Specialty Codes	Provider Secondary Specialty Codes	In-State Provider Document Requirements ³
32 – Waiver	359 – Community Integration and Habilitation Waiver	C00 – Adult Day Services (Level 1, 2, 3) C01 – Adult Foster Care ¹ C02 – Behavior Management/Behavior Program & Counseling C03 – Community-Based Habilitation – Group C04 – Community-Based Habilitation – Individual C05 – Community Transition Services C06 – Electronic Monitoring C07 – Environmental Modifications C08 – Facility-Based Habilitation – Group C09 – Facility-Based Habilitation – Individual C10 – Facility-Based Support Services C11 – Family and Caregiver Training C12 – Intensive Behavioral Intervention C13 – Music Therapy ¹ C14 – Occupational Therapy C15 – Personal Emergency Response Systems C16 – Physical Therapy ¹ C17 – Prevocational Services C18 – Psychological Therapy C19 – Recreational Therapy ¹ C20 – Rent/Food for Unrelated Live-In Caregiver C21 – Residential Habilitation and Support C22 – Respite C23 – Specialized Medical Equipment & Supplies ^{1,2} C24 – Speech/Language Therapy ¹ C25 – Extended Services C26 – Transportation Level 1 ¹ C27 – Workplace Assistance C28 – Case Management C29 – Transportation Level 2 ¹ C30 – Transportation Level 3 ¹ C31 – Wellness Coordination	<ul style="list-style-type: none"> IHCP Waiver provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Certification letter from the appropriate waiver administering division C01 – Application fee required ¹ C13 – Application fee required, if group ¹ C14 – Application fee required, if group ¹ C16 – Application fee required, if group ¹ C19 – Application fee required, if group ¹ C23 – Application fee, fingerprint, and background check required ^{1,2} C24 – Application fee required, if group ¹ C26 – Application fee required ¹ C29 – Application fee required ¹ C30 – Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

³ Out-of-state providers must contact the appropriate waiver division for requirements.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code	Provider Specialty Codes	Provider Secondary Specialty Codes	In-State Provider Document Requirements ³
32 – Waiver	360 – Family Supports Waiver	D00 – Adult Day Services (Level 1, 2, 3) D01 – Behavior Management/Behavior Program & Counseling D02 – Community-Based Habilitation – Group D03 – Community-Based Habilitation – Individual D04 – Facility-Based Habilitation – Group D05 – Facility-Based Habilitation – Individual D06 – Facility-Based Support Services D07 – Family and Caregiver Training D08 – Intensive Behavioral Intervention D09 – Music Therapy ¹ D10 – Occupational Therapy ¹ D11 – Personal Emergency Response Systems D12 – Speech/Language Therapy ¹ D13 – Physical Therapy ¹ D14 – Prevocational Services D15 – Psychological Therapy D16 – Recreational Therapy ¹ D17 – Respite D18 – Specialized Medical Equipment & Supplies ^{1,2} D19 – Extended Services D20 – Transportation ¹ D21 – Workplace Assistance D22 – Case Management D23 – Participant Assistance and Care	<ul style="list-style-type: none"> IHCP Waiver provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Certification letter from the appropriate waiver administering division D09 – Application fee required, if group ¹ D10 – Application fee required, if group ¹ D12 – Application fee required, if group ¹ D13 – Application fee required, if group ¹ D16 – Application fee required, if group ¹ D18 – Application fee, fingerprint, and background check required ^{1,2} D20 – Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

³ Out-of-state providers must contact the appropriate waiver division for requirements.

IHCP Provider Enrollment Type and Specialty Matrix



Provider Type Code	Provider Specialty Codes	Provider Secondary Specialty Codes	In-State Provider Document Requirements ³
32 – Waiver	363 – Money Follows the Person (MFP) Demonstration Grant	F00 – Adult Day Services (Level 1) F01 – Adult Day Services (Level 2) F02 – Adult Day Services (Level 3) F03 – Adult Foster Care ¹ F04 – Assisted Living F05 – Attendant Care ² F06 – Behavior Management/Behavior Program & Counseling F07 – Case Management F08 – Community-Based Habilitation – Individual F09 – Community-Based Habilitation – Group F10 – Community Transition Services F11 – Electronic Monitoring F12 – Environmental Modifications F13 – Facility-Based Habilitation – Group F14 – Facility-Based Habilitation – Individual F27 – Prevocational Services F28 – Psychological Therapy F29 – Recreational Therapy ¹ F30 – Rent/Food for Unrelated Live-In Caregiver F31 – Residential Habilitation and Support F32 – Respite F33 – Self-Directed Attendant Care F34 – Specialized Medical Equipment & Supplies ^{1, 2} F35 – Speech/Language Therapy ¹ F36 – Structured Day Program F37 – Supported Employment Follow-Along F38 – Transportation ¹ F39 – Vehicle Modifications F40 – Workplace Assistance F41 – Environmental Modifications Assessment F42 – Structured Family Caregiving F43 – Wellness Coordination F44 – Extended Services	<ul style="list-style-type: none"> IHCP Waiver provider enrollment packet or online application for your classification, which includes: <ul style="list-style-type: none"> Provider Agreement Federal W-9 form Certification letter from the appropriate waiver administering division F03 – Application fee required ¹ F05 – Fingerprint and background check required ² F21 – Application fee required, if group ¹ F23 – Application fee required, if group ¹ F26 – Application fee required, if group ¹ F29 – Application fee required, if group ¹ F34 – Application fee, fingerprint, and background check required^{1, 2} F35 – Application fee required, if group ¹ F38 – Application fee required ¹

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

³ Out-of-state providers must contact the appropriate waiver division for requirements.